SPHERE Summer Program 2026

YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS AND STAFF

Physical Exams Are Valid For 3 Years From Date of Last Examination

Even if you are a returning participant, new forms must be filled out each year.

☐ Camper

☐ Staff (Teachers, counselors, and CITs)

Name _____ Date of Birth _____ Phone _____

Address _____

Guardian Name (if under 18) _____ Telephone _____

Emergency Contact Name _____ Telephone _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

Date of Exam ____/____/____

_____ May participate in all camp activities

_____ May participate except for: _____

Medical information pertinent to routine care and emergencies:_____

_____

Is this individual taking prescription or over the counter medication(s)? □ YES □ NO If yes, indicate names of medication(s):

_____

Does the individual have allergies? □ YES □ NO Explain**:** _____

Is the individual on a special diet? □ YES □ NO Explain**:** _____

Does the individual have special needs? □ YES □ NO Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently required by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: _____

_____

Medical Care Provider Name: _____

Medical Care Provider Address: _____

_____ _____ _____

Signature of Physician, PA, APRN or RN | Telephone Number | Date

SPHERE Summer Program
180 Bloomfield Ave Hartford CT 06105
Ph-860.236.5618 FAX-860.233.8295

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SPHERE Staff

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated director or first aid instructor to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ None expected ☐ Specify:
_____

ALLERGIES: ☐ NO ☐ YES (*specify*):
_____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
Telephone: _____ Fax: _____
Address: _____
_____

Prescriber's Signature: _____ Date: _____

Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by SPHERE staff. I understand that I must supply SPHERE with no more than a 45 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following the last day of SPHERE.

Parent/Guardian Signature: _____ Date: _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the nurse and or Director of First Aid.

Prescriber's authorization for self administration: ☐ Yes ☐ No _____
Signature Date

Parent/Guardian authorization for self administration: ☐ Yes ☐ No
_____
Signature Date

Summer Immersion Nurse approval for self administration: ☐ Yes ☐ No

_____

Signature Date